



California Health Benefit Exchange

The Supplemental Dental and Pediatric Dental Essential Health Benefit Solicitation (“Dental Plan Solicitation”) was amended on March 29, 2013 and contains the following changes:

1. Page 10 Section G. Key Action Dates:
 - *Added date for release of revised Supplemental Benefit plan designs: 03/18/2013*
 - *Denoted different dates for Standalone Pediatric Dental EHB non-rate and rate responses: 04/02/2013 and 04/08/2013, respectively*
 - *Added separate date for Supplemental Dental bidder response submission: 5/01/2013*
 - *Added separate date for certification notices to be sent to Supplemental bidders: 06/14/2013*
 - *Added separate projected date for execution of contracts with selected Supplemental dental plan issuers: 07/01/2013*

The Supplemental Dental and Pediatric Dental Essential Health Benefit Solicitation was amended on February 1, 2013 and contains the following changes:

2. Page 9 Section G under Action column – *Added “Tentative” to the May 15th line item indicating that tentative certification notices will be sent to QDP bidders on that date*
3. Pages 3-19 – *Removed “DRAFT” from top right corner*
4. Page 15 Section F- 1. – *Removed footnote “For SHOP Exchange bidders only”*



California Health Benefit Exchange

California Health Benefit Exchange
2012 - 2013 Solicitation to Dental Issuers
And Invitation to Respond

Exchange Dental Benefits Solicitation
HBEX 15

January 8, 2013

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I. GENERAL INFORMATION AND BACKGROUND

A. PURPOSE

The California Health Benefit Exchange (Exchange) is soliciting responses from dental issuers¹ (Bidders²) to submit bids to offer, market, and sell dental plans through the Exchange beginning in 2013. The Exchange will exercise its statutory authority as an “active purchaser³ in reviewing submitted bids and reserves the right to select or reject any dental plan or to cancel this solicitation at any time. This solicitation invites responses from vendors for both the Stand-Alone dental plans that will be considered for coverage of the Pediatric Dental Essential Health Benefits (EHB), and for Supplemental Benefits that may be purchased on a voluntary basis. The Exchange seeks to award a limited number of contracts related to the EHB and to the Supplemental Benefits for each geographic region, while ensuring that statewide coverage is available.

Bids will be accepted from any organization that is licensed to sell a dental insurance product, including dental plans and health plans that offer dental coverage separate from medical coverage. The Exchange will consider bids from coalitions. If bidders are a coalition of multiple dental issuers it is required that a Primary Issuer take responsibility for aggregating and managing the coalition members. All issuers who are members of the coalition will be required to be a party to the coalition contract with the Exchange and must individually meet the Exchange's criteria, including requirements for licensure and good standing and must respond to each solicitation item that requires a response at the entity level. The Exchange reserves the right to contract with only a subset of the issuers who form a coalition.

Bids are sought from the following types of plans for these two products:

- **Pediatric Essential Dental Health Benefits**
 - Statewide dental plans
 - Regional individual DHMO plans
 - Regional SHOP DHMO plans
- **Supplemental Dental Benefits**
 - Statewide dental plans
 - Regional individual DHMO plans
 - Regional SHOP DHMO plans

The Exchange welcomes dental issuers to bid on both EHB and Supplemental Products. Bidders licensed in both the Individual and SHOP markets are encouraged to bid both market segments.

This dental plan solicitation may be amended by addenda at any time. Issuers who have responded to the Notice of Intent to Bid will be notified of posted changes to the solicitation; all interested bidders may obtain information and updates from the Exchange's web site.

The matter contained in this document is strictly related to the initial year Issuer dental plan applications. The Exchange has not yet made decisions about the process for decertification and any related annual or other periodic recertification requirements related to dental plans contracted for EHBs. Renewal processes related to the Supplemental Dental contracts are also still to be determined.

B. BACKGROUND

Soon after the passage of national health care reform through the Patient Protection and Affordable Care Act of 2010 (ACA), California became the first state to enact legislation to establish a health benefit exchange. (Chapter 655, Statutes of 2010-Perez and Chapter 659, Statutes of 2010-Alquist.) The California state law is referred to as the California Patient Protection and Affordable Care Act (CA-ACA).

¹ The term “dental issuer” used in this document refers to dental plans regulated by the California Department of Managed Health Care or the California Department of Insurance. It also refers to the company issuing dental coverage

² The term “bidder” refers to a dental plan issuer who is seeking a Dental Plan contract with the Exchange.

³ California GC §100505 per AB 1602 §9

Effective January 1, 2014, the California Health Benefit Exchange will be operating a state-wide health insurance exchange to make it easier for individuals and small businesses to compare plans and buy health, dental and vision insurance in the private market, with enrollment beginning October 1, 2013. Although the focus of the Exchange will be on individuals and small businesses who qualify for tax credits and subsidies under the Affordable Care Act, the Exchange's goal is to make insurance available to all qualified individuals and to all California businesses with fewer than 50 employees.

The vision of the California Health Benefit Exchange is to improve the health of all Californians by assuring their access to affordable, high quality health care coverage. The mission of the California Health Benefit Exchange is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

The California Health Benefit Exchange is guided by the following values:

- **Consumer-Focused:** At the center of the Exchange's efforts are the people it serves, including patients and their families, and small business owners and their employees. The Exchange will offer a consumer-friendly experience that is accessible to all Californians, recognizing the diverse cultural, language, economic, educational and health status needs of those it serves.
- **Affordability:** The Exchange will provide affordable health insurances while assuring quality and access.
- **Catalyst:** The Exchange will be a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable healthcare, promoting prevention and wellness, and reducing health disparities.
- **Integrity:** The Exchange will earn the public's trust through its commitment to accountability, responsiveness, transparency, speed, agility, reliability, and cooperation.
- **Partnership:** The Exchange welcomes partnerships, and its efforts will be guided by working with consumers, providers, health plans, employers and other purchasers, government partners, and other stakeholders.
- **Results:** The impact of the Exchange will be measured by its contributions to expanding coverage and access, improving health care quality, promoting better health and health equity, and lowering costs for all Californians.

In addition to being guided by its mission and values, the Exchange's policies are derived from the Federal Affordable Care Act which calls upon Exchanges to advance "plan or coverage benefits and health care provider reimbursement structures" that improve health outcomes. The California Health Benefit Exchange seeks to improve the quality of care while moderating cost not only for the individuals enrolled in its plans, but also by being a catalyst for delivery system reform in partnership with plans, providers and consumers. With the Affordable Care Act and the range of insurance market reforms that are in the process of being implemented, the health insurance marketplace will be transformed from one that has focused on risk selection to achieve profitability to one that will reward better care, affordability, and prevention.

The Exchange needs to address these issues for the millions of Californians who will enroll through it to get coverage, but also must be part of broader efforts to improve care, improve health, and control health care costs.

The California Health Benefit Exchange must operate within the federal standards in law and regulation. Beyond what is framed by the federal standards, California's legislature shapes the standards and defines how the new marketplace for individual and small group health insurance will operate in ways specific to their context. Within the requirements of the minimum Federal criteria and standards, the Exchange has the responsibility to "certify" the Qualified Plans that will be offered in the Exchange for Essential Health Benefits.

The state legislation to establish the California Health Benefit Exchange directed it to "selectively contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service" and to establish and use a competitive process to select the participating health plan issuers⁴.

These concepts, and the inherent trade-offs among the California Health Benefit Exchange values, must be balanced in the evaluation and selection of the Qualified Dental Plans (those that are contracted through the Exchange to provide Essential Health Benefits) and Supplemental Benefit Plans that will be offered on the Individual and the SHOP Exchanges.

As outlined in the Board Options and Recommendations Briefs for Qualified Health Plan Policies and Strategies, the plan selection will influence how competitive the market will be, the cost of coverage, and strategies to add value through health care delivery system improvement.

1. PRINCIPLES OF EVALUATION OF ISSUER DENTAL PLAN BIDS

While evaluating the dental plan bids, the Exchange will consider the mix of dental plans that best meet the Exchange's goals of providing an appropriate range of high quality choice to participants at the best available price, while promoting the broad goals described above. In consideration of the mission and values of the Exchange, there are a number of evaluation principles that will be applied. These include the following:

- Encourage "Value" Competition Based upon Quality, Service, and Price

While premium price will be a key consideration, contracts will be awarded based on determination of "best value" to the Exchange and its participants. The evaluation of issuer dental plan bids will also focus on quality and service components, including past history of performance, reported quality and satisfaction metrics, and commitment to serve the Exchange population through cooperation with the Exchange operations, provider network adequacy, and cultural and linguistic competency. We expect that some necessary regulatory requirements may need to be completed after the due date for this dental plan solicitation. The solicitation responses, in conjunction with the offered pricing, will be weighted to develop a measure of overall "value" that will be used to select the initial dental plans that will be offered on the Exchanges.

- Encourage Competition Based upon Meaningful Dental Plan Choice and Product Differentiation: Standard Benefit Plan Designs

The Exchange is committed to fostering competition by offering dental plans with features that present clear choice and product differentiation. Dental plan bidders are required to bid at least one of the Exchange's adopted standardized benefit plan designs (DPPO or DHMO) and both actuarial value levels for the bid plan designs, in each region for which they submit a bid. The Exchange welcomes dental issuers to bid on both EHB and Supplemental Products. To the extent possible, both DHMO and DPPO products will be offered. Within a given product design, the Exchange will look for differences in network providers. Under such criteria, the Exchange may choose not to contract with two plans with overlapping networks within a rating region.

- Encourage Competition throughout the State

The Exchange must be statewide. Issuers are required to submit dental plan bids in all geographic service areas in which they are licensed, and preference will be given to issuers that develop dental plan bids that meet quality and service criteria while offering coverage options that provide reasonable access to the geographically underserved areas of the state as well as the more densely populated areas.

⁴ California Government Code §§100503(c) (AB 1602 §7), and 100505 (AB 1602 §9).
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- Encourage Alignment with Providers and Delivery Systems that Serve the Low Income Population

An important role of the Exchange is outreach and enrollment of the low income and culturally diverse population that will be eligible for premium tax credits and cost sharing subsidies through the Exchange. Responses that demonstrate an ongoing commitment or have developed the capacity to serve the cultural, linguistic and dental care needs of the low income and uninsured populations, beyond the minimum requirements adopted by the Exchange, will receive additional consideration. Examples of demonstrated commitment may include contracting with Federally Qualified Health Centers or other organizations that traditionally serve the low income population.

C. AVAILABILITY

The dental plan bidder/issuer must be available immediately upon certification as a dental plan to start working with the Exchange to establish all operational procedures necessary to integrate and interface with the Exchange information systems, and to provide additional information necessary for the Exchange to market, enroll members, and provide dental plan services effective January 1, 2014. Successful bidders will also be required to adhere to certain provisions through their contracts with the Exchange including but not limited to meeting data interface requirements with CalHEERS⁵. The Exchange expects to negotiate and sign contracts prior to June 1, 2013. The successful bidders must be ready and able to accept enrollment as of October 1, 2013.

D. CLARIFICATION QUESTIONS

Bidders may submit questions in writing, including via email, to the Solicitation Official listed in Section H of this solicitation by the due date specified in the Key Action Dates table in Section G. Bidders who submit a Letter of Intent may be notified via email when responses to questions have been posted, but are responsible for checking the Exchange's web site to obtain the responses. The Exchange takes no responsibility for a bidder's failure to receive responses to questions or any Solicitation addenda. The Exchange will accept and respond to inquiries during the question and answer timeframes outlined in the Key Action Dates. Beyond this defined timeframe, The Exchange will respond to bidder questions at its discretion. The Exchange reserves the right to respond only to questions submitted by bidders that submit a non-binding Letter of Intent to Bid (see Section E). Bidders shall provide specific information to enable the Exchange to identify and respond to their questions. At its discretion, the Exchange may contact an inquirer to seek clarification of any inquiry received. Bidders that fail to report a known or suspected problem with the solicitation, or that fail to seek clarification and/or correction of the solicitation, submit responses at their own risk.

E. INTENTION TO SUBMIT A RESPONSE

Bidders interested in responding to this solicitation should submit the completed Intent to Bid form, provided in Attachment 1, indicating their interest in bidding and their proposed products, service areas and the like and to ensure receipt of additional information. Only those bidders acknowledging interest in this solicitation by submitting a notification of intention to submit a bid will continue to receive solicitation-related correspondence throughout the solicitation process.

The bidder's intent to bid form will identify the contact person for the solicitation process, along with contact information that includes an email address and a telephone number. The Intent to Bid form will be due by 12:00 noon PST on Monday, January 16, 2013. It may be submitted by email to the Solicitation Official identified in Section H.

An issuer's submission of an Intent to Bid will be considered confidential information and not available to the public; the Exchange reserves the right to release aggregate information about issuers' responses. Confidentiality is to be held by the Exchange; bidder information will not be released to the public but may be shared with appropriate regulators as part of the cooperative arrangement between the Exchange and the regulators.

⁵ California Healthcare Eligibility, Enrollments and Retention System -- The Exchange's eligibility and enrollment system
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The Exchange will correspond with only one (1) contact person per bidder. It shall be the bidder's responsibility to immediately notify the Solicitation Official identified in Section H, in writing, regarding any revision to the contact information. The Exchange shall not be responsible for solicitation correspondence not received by the bidder if the bidder fails to notify the Exchange, in writing, of any changes pertaining to the designated contact person.

F. SOLICITATION ADDENDA

All addenda to the solicitation will be posted within the Bidder's Library under the Dental Solicitation Tab on the Exchange's website at: www.hbex.ca.gov.

Bidders may access documents and information here that may be useful for developing their responses. As further documentation related to the solicitation becomes available it will be posted here. Amendments to this Solicitation will not be issued when new information is posted to The Exchange's website. Bidders are encouraged to continuously monitor The Exchange's website.

G. KEY ACTION DATES

Listed below is a series of key actions related to this solicitation, along with the corresponding dates and times by which each key action must be taken or completed. If the Exchange finds it necessary to change any of these dates, such changes will be accomplished through addenda to this solicitation. All dates subsequent to the final response submission deadline are approximate and may be adjusted as conditions warrant, without addenda to this solicitation.

Action	Date/Time
Release of Solicitation	01/08/2013
Questions from bidders due to the Exchange	01/16/2013
Intent to Bid notifications due to Exchange	01/16/2013
Revised Supplemental benefit plan designs posted for Supplemental Dental and Vision	New: 03/18/2013
Submission of Standalone Pediatric Dental EHB bidder non-rate responses	04/02/2013 (12:00 noon PST)
Submission of Standalone Pediatric Dental EHB bidder rate responses	New: 04/08/2013 (5:00 PM PST)
Submission of Supplemental Dental bidder responses (12:00 noon PST)	Revised: 05/01/2013
Tentative Certification notices to be sent to QDP bidders	05/15/2013
Tentative Certification notices to be sent to Supplemental bidders	Revised: 06/14/2013
Execution of contracts with selected EHB dental plan issuers (projected)	06/01/2013
Execution of contracts with selected Supplemental dental plan issuers	Revised: 07/01/2013

H. SOLICITATION OFFICIAL

The Solicitation Official is the single point of contact for this solicitation. Please submit all correspondence to:

Katherine VanderSchaaf
The California Health Benefit Exchange
560 J Street, Suite 290
Sacramento, CA 95814
Office: 916.323.3766
Email: SHOP@hbex.ca.gov

II. TECHNICAL REQUIREMENTS

Bidders are required to provide the information requested below. The responses must be provided through completion of the accompanying attachments.

A. LICENSED AND IN GOOD STANDING AND REGULATORY FILINGS

1. LICENSED AND IN GOOD STANDING

- a) In addition to holding all of the proper and required licenses⁶ to operate as a dental plan issuer as defined herein, the bidder must demonstrate that it is in good standing with all appropriate local, state, and federal licensing authorities. Good standing means that the bidder has had no material fines, penalties levied, citations, or ongoing disputes with applicable licensing authorities in the last two years.
Please refer to Attachment 3 to provide your confirmation.

- b). The bidder must acknowledge any ongoing labor disputes, penalties, fines, or corrective action citations for federal or state workplace safety issues.
Please refer to Attachment 3 to provide your acknowledgement.

2. NEW APPLICATION OR MATERIAL MODIFICATION OF AN EXISTING LICENSE OR CERTIFICATE OF AUTHORITY

- a) The bidder must acknowledge whether it is seeking a certificate of authority or an amendment to an existing certificate of authority from the relevant regulatory agency in order to meet the requirements of individual and small group products to be offered on the California Health Benefit Exchange.

Please refer to Attachment 3 to provide your acknowledgement. If such a certificate or amendment is sought, refer to Attachment 4 to provide the requested details.

3. DENTAL PLAN REGULATORY FILINGS

- a) Separate from the bidder's response to this solicitation, a bidder is responsible for submitting all required material to the California regulatory agency necessary to obtain approval of products/plans that are to be submitted in response to this solicitation. Bidder must acknowledge that all such product filings have been submitted for regulatory review.

Please refer to Attachment 3 to provide your acknowledgement. Refer to Attachment 5 to provide the requested details associated with such product filings

- b). The California Department of Managed Care and the California Department of Insurance (CDI) have primary responsibility for regulatory review and issuing preliminary recommendations to the Exchange of certain selection criteria listed below in the definition of good standing in addition to applying the minimum licensure requirements. The Issuer is expected to be responsive to questions raised by the agencies in their review.

Please refer to Attachment 3, to provide your confirmation.

⁶ The Exchange reserves the right to require licenses to be in place at the time of dental plan selection in the case of new applicants for licenses. Bidders who are not yet licensed should indicate anticipated date of licensure.
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The agencies will conduct the review of:

Definition of Good Standing	Agency	Relevant To EHB	Relevant to Supplemental
<u>Verification that issuer holds a state health care service plan license or insurance certificate of authority.</u>			
• Approved for what lines of business (e.g. commercial, small group, individual)	DMHC	X	X
• Approved to operate in what geographic service areas	DMHC	X	X
• Most recent financial exam and medical survey report	DMHC	X	X
• Most recent market conduct exam	CDI	X	X
<u>Affirmation of no material⁷ statutory or regulatory violations, including penalties levied, in the past two years in relation to any of the following, where applicable:</u>			
• Financial solvency and reserves	DMHC and CDI	X	X
• Administrative and organizational capacity	DMHC	X	X
• Benefit Design			
• State mandates (to cover and to offer)	DMHC and CDI	X	
• Essential health benefits ⁸ Pediatric Dental only (as of 2014)	DMHC and CDI	X	
• Basic health care services	DMHC and CDI	X	
• Copayments, deductibles, out-of-pocket maximums	DMHC and CDI	X	
• Actuarial value confirmation (per Federal rules)	DMHC and CDI	X	
• Network adequacy and accessibility standards	DMHC and CDI	X	
• Provider contracts	DMHC and CDI	X	
• Uniform disclosure (summary of benefits and coverage)	DMHC and CDI	X	
• Claims payment policies and practices	DMHC and CDI	X	X
• Provider complaints	DMHC and CDI	X	X
• Utilization review policies and practices	DMHC and CDI	X	X
• Quality assurance/management policies and practices	DMHC	X	
• Enrollee/Member grievances/complaints and appeals policies and practices	DMHC and CDI	X	X
• Independent medical review	DMHC and CDI	X	
• Marketing and advertising	DMHC and CDI	X	
• Guaranteed issue individual and small group (as of 2014)	DMHC and CDI	X	X

⁷ Material violations are those that represent a relevant and significant departure from normal business standards that a health plan issuer is expected to adhere to.

⁸ Certain listed items, such as essential health benefits and actuarial value, are not required until 2014.

B. CALIFORNIA HEALTH BENEFIT EXCHANGE DENTAL PLAN QUESTIONS

1. PLAN NETWORK DESIGN ISSUES

Bidder must certify that for each rating region in which it submits a dental plan bid it is submitting bids for the two required levels of actuarial value (75% and 85%) for EHB and/or for Supplemental Benefits. A dental plan product is defined as a standardized plan design and uses the same provider network in a family of plans or insurance policies across all actuarial values. **Note that the Exchange has provided Standard Plan Designs in Attachment 15 (EHB) and Attachment 16 (Supplemental). Bidders are welcome to provide comments regarding the Standard Plan Designs for Supplemental Benefits prior to January 16, 2013; the Standard Plan Designs for Essential Health Benefits are considered final. Once the Supplemental Benefits Standard Plan Designs have been finalized, they will be posted to Bidder's Library as addenda to this solicitation.** Also note that the Exchange has adopted the small group rating regions definition as determined in AB 1083, chapter 852 as of September 30, 2012 for the Individual Market until further legislation is enacted.

- a) Dental plans must submit a bid for at least one of the standard plan designs. Separate bids are required for EHB and for the Supplemental Plan.

Please refer to Attachment 3 to provide your confirmation. Please refer to Attachment 6 to indicate the rating regions and number of plans for which you are proposing a dental bid.

- b) Bidders are required to bid their entire licensed service area, and must certify that they have done so. Bidders may choose to bid for only their Individual or Small Group licensed area, or may offer coverage in both markets. Bidders may also choose whether to offer EHB and/or Supplemental coverage; separate bids must be provided for each product. Bidders licensed in both the Individual and SHOP markets are encouraged to bid both market segments.

Please refer to Attachment 3 to provide your confirmation. Please refer to Attachment 7 to complete the crosswalk of licensed service area zip codes and rating region for each dental plan product.

2. CONTRACTING WITH DENTAL PROVIDERS WHO SERVE THE LOW INCOME AND UNINSURED POPULATIONS

- a) For EHBs, bidders should demonstrate the extent to which their bid includes participation of dental providers with a history of serving low-income and uninsured populations. Preference will be given to those bidders that include providers with a history of serving the low income and uninsured population.

Bidders shall use the county low income population data to submit the following geo-maps of each county within the proposed geographic service area (county maps may be aggregated for the service area).

- (1) FQHC providers plotted on a low-income population map, by county.
- (2) Other providers that serve the low-income population, defined as those providers for whom at least 20% of patients served are low income, by county. Note that a proxy for low-income patients may be MediCal or Healthy Families enrollees or individuals eligible for income-based fee consideration.

County data on distribution of the California Low-Income Population is available within the Bidder's Library under the Dental Solicitation Tab on the Exchange's website. Low-income is defined as a family at or below 200% of Federal Poverty Level. The data supplied will allow bidders to plot contracted FQHC locations on county maps which display the low-income population. Issuers will be responsible for mapping other low-income providers.

3. QUALITY IMPROVEMENT STRATEGY - PROMOTING - BETTER CARE, BETTER HEALTH, AND LOWER COST

Consistent with The Exchange's mission to promote better care, better health and lower cost as part of a Quality Improvement Strategy, please refer to Attachment 3 to provide statements confirming your organization will:

- a). Implement a quality assurance program in accordance with Title 2, CCR, Section 1300.70, for evaluating the appropriateness and quality of the covered services provide to members
- b). Maintain a system of accountability for quality improvement in accordance with all applicable statutes and regulations, monitoring, evaluating and taking effective action to address any needed improvements, as identified by The Exchange, in the quality of care delivered to members.

C. TECHNICAL SPECIFICATIONS

Please refer to Attachment 11 to respond to Technical Specification questions, confirmations and requests for information. These requests are organized into the following categories:

1. GENERAL
2. ACCOUNT MANAGEMENT SUPPORT
3. IMPLEMENTATION
4. ACCOUNT ADMINISTRATION
5. MEMBER SERVICES
6. CARE MANAGEMENT
7. COMMUNICATIONS & EDUCATION
8. PROVIDER NETWORK
9. SYSTEMS AND DATA REPORTING MANAGEMENT

D. PERFORMANCE MEASURES (QUALITY)

Please refer to Attachment 12 to provide your organization's performance measures relevant to the rating regions for which you are bidding. If you are bidding for a region for which you do not have recent experience, provide your experience for California and note the reason that region specific experience is not available. If you do not have recent California experience provide your national experience and note the reason that California experience is not available.

E. DOCUMENTATION

Please confirm in Attachment 13 that you have provided the following documentation for The Exchange's review.

1. An organizational chart of your California operations, including individual and small group line(s) of business
2. An organizational chart for the team proposed to service the Exchange account. Show lines of authority up to and including the executive management level. Include all functions such as account management, claims, member services, billing, individual and small group sales and marketing department etc.
3. A listing of the individual(s) who will have primary responsibility for servicing the Exchange account. Please indicate where these individuals fit into the organizational chart requested above. Please include the following information and repeat as necessary.

- Name
 - Title
 - Department
 - Primary responsibilities
 - Phone
 - Fax
 - E-mail
4. An implementation project plan and timeline including all necessary steps and events (including testing), required to achieve full implementation by January 1, 2014
 5. Audited financial statements for the past two (2) available years, or in their absence, provide documentation that allows for the assessment of your organizations financial stability.
 6. A sample ID card.
 7. Samples of the following standard member communications materials:
 - Introductory pre-open enrolment
 - Welcome package
 - Summary plan description (SPD)
 - Preventive reminders
 - Explanation of benefits (EOB)
 8. An excerpt of your provider network directory for a zip code, or access to your online directory.
 9. A standard claims form and the associated claim submission instructions.
 10. A sample customer satisfaction survey
 11. The most recent customer service survey results
 12. The web address to access your online provider directory

F. ADDITIONAL QUESTIONS AND/OR REQUIREMENTS

Please refer to Attachment 14 to respond to all Additional Questions and/or Requirements. These requests are organized into the following categories:

1. AGENT RELATIONS, FEES, AND COMMISSIONS
2. MARKETING AND OUTREACH ACTIVITIES
3. OPERATIONAL REPORTING REQUIREMENTS AND INTERFACES

Reporting requirements will be developed to allow the Issuer to maintain interfaces with the Exchange portal and for the Exchange to monitor Issuer operational performance. For example, dental plans will be required to provide provider network data to allow the Exchange to create a centralized provider directory. Required provider data elements will be provided soon.

Further, dental plans will be required to build data interfaces with the Exchange's eligibility and enrollment systems and to report on transactions. Technical requirements are under development at this time.

III. COST PROPOSAL

A. REQUIREMENTS

Final negotiated and accepted premium bids shall be in effect for the first full year of operation of the Exchange, effective January 1, 2014, or for the SHOP plan year for each enrolled employer group. Premium bids are considered preliminary and may be subject to negotiation as part of dental plan certification and selection.

B. INSTRUCTIONS

Complete Attachments 8, 9 and 10 to provide your premium bids for the Pediatric Dental EHB, Supplemental - Individual and Supplemental- SHOP plans and market segments. For each dental plan product, enter preliminary premium for dental plan products to be offered in the Exchange. Premium may vary only by geography (rating region), by coverage tier, and by actuarial value level. For SHOP coverage, plans may provide annual 2014 rates that are effective January 1, April 1, July 1 and October 1.

Volume II – Cost Proposal will remain sealed until the evaluation of Volume I is completed.

IV. PROPOSAL PREPARATION & SUBMISSION INSTRUCTIONS

A. INTRODUCTION

This section provides instructions for preparation of the bidder's proposal response as well as the response submission (including response packaging) and response evaluation.

B. FINAL RESPONSE FORMAT AND CONTENTS

These instructions describe the mandatory response format and the required approach for the development and presentation of response data. Format instructions must be adhered to, all requirements and questions in the solicitation must be responded to, and all requested data must be supplied.

The Exchange intends to make the entirety of this solicitation available electronically. Each dental plan bidder will be required to identify a primary solicitation respondent but that individual may, in turn, designate internal subject matter experts for responding.

It is the bidder's responsibility to ensure its response is submitted in a manner that enables the Exchange Evaluation Team to easily locate response descriptions and exhibits for each requirement.

1. GENERAL INSTRUCTIONS

- a) Each firm may submit only one response as a primary vendor, and up to one response as a member of a coalition that organizes to offer broad geographic coverage. Coalition members must individually respond to all questions related to licensure, in good standing, provider network, and other items that describe the ability of the issuer to serve the Exchange population. For the purposes of this paragraph, "firm" includes a parent corporation of a firm and any other subsidiary of that parent corporation. If a firm submits more than one response, the Exchange will reject all responses submitted by that firm.
- b) Develop responses by following all solicitation instructions and/or clarifications issued by the Exchange in the form of question and answer notices, clarification notices or solicitation addenda.
- c) Before submitting a response, seek timely written clarification of any requirements or instructions that are believed to be vague, unclear or that are not fully understood. These inquiries should be made during the timeframe outlined in the solicitation timeline except in emergencies.
- d) In preparing a response, all narrative portions should be straightforward, detailed and concise, and shall be provided within the designated space requirements for each item. The Exchange will determine the responsiveness of a proposal by its quality, not its quantity, volume, packaging or color displays.

C. PROPOSAL SUBMISSION

This subsection addresses the proposal response submission and packaging.

Your Response should be provided in two, separately packaged volumes:

- 1). Volume I: Technical Requirements (Attachments 2-7 and Attachments 11-14)
- 2). Volume II: Cost Proposal (Attachments 8-10)

The Issuer must submit five (5) hard copies of Volume 1 and five (5) hard copies of Volume 2, packaged in two separate and sealed envelopes. One (1) complete set of each of the required volumes must be clearly marked "MASTER COPY."

Copies must include a cover letter with the following information:

- **Bidder's Company Name, mailing address and telephone number**
- **Contact Person's name, title, email address, telephone number and fax number**
- **Title of this bid**
- **Federal tax identification number**
- **Submission date of proposal**
- **Original signature of an individual authorized to enter into contracts on behalf of the bidder (provided in blue ink)**

The Issuer must submit one (1) copy of the Volume 1 response in searchable PDF format, on CD and enclosed with the hard Master Copy of Volume 1. The CD must be identical to, and contain everything included in the Master Copy of Volume 1. However, signatures may be omitted from the cover letter on the CD. The CD must *not* contain any cost information.

The Issuer must submit one (1) copy of the Volume 2 (Cost Proposal) response, in Excel 2003 or later, along with the cover letter in PDF format, one CD and enclosed with the hard Master Copy of Volume 2. The CD

must be identical to, and contain everything included in, the Master Copy of Volume 2. However, signatures may be omitted from the cover letter on the CD.

During the bidding process all responses will be kept confidential.

All responses must be delivered to the Procurement Official listed in Section H by the date and time listed in Section G, Key Action Dates.

V. EVALUATION

A. INTRODUCTION

This section presents the evaluation process the Exchange will follow in reviewing responses submitted related to this solicitation.

The Exchange will conduct a comprehensive, fair, and impartial evaluation of proposals received in response to this Solicitation. The Exchange will select the successful plans through a formal evaluation process, established prior to the opening and evaluation of proposals, and remaining fixed throughout the procurement cycle. The successful plans will be selected based on demonstrated ability to satisfactorily perform the Services required.

Final Responses must be received by the Solicitation Official no later than the date and time specified in Section G, Key Action Dates. Late responses will be rejected.

The Exchange will appoint an Evaluation Team to conduct the response evaluation by consensus and assess whether the proposal is responsive and may proceed to the evaluation of the Response to Requirements. The Exchange reserves the right to request additional information to resolve minor irregularities in Proposals and/or to waive minor irregularities, providing that such action be deemed to be in the best interest of the Exchange.

Final selection will be on the basis of compliance with the proposal preparation requirements. Responses which are not responsive to the proposal preparation requirements may be deemed non-responsive and excluded from further consideration by the Exchange.

B. RECEIPT

Upon receipt, Exchange staff will date and time mark every response and verify that all responses are submitted under an appropriate cover, sealed, and properly identified. Responses or modifications to any previously submitted response will not be accepted after the Submission Date indicated in Section G, Key Action Dates. Cost proposals will remain sealed until the evaluation of Volume 1 is complete.

VI. ATTACHMENTS

1. INTENT TO BID FORM
2. BIDDER CHECKLIST
3. CONFIRMATION
4. LICENSES
5. PRODUCT FILINGS
6. PLAN/PRODUCT BIDS BY RATING REGION
7. LICENSED GEOGRAPHIC SERVICE ARREST
8. PREMIUM TABLES (EHB)
9. PREMIUM TABLES (SUPPLEMENTAL INDIVIDUAL)
10. PREMIUM TABLES (SUPPLEMENTAL SHOP)
11. TECHNICAL SPECIFICATIONS
12. PERFORMANCE MEASURES
13. CONFIRMATIONS OF PROVIDED DOCUMENTATION
14. ADDITIONAL QUESTIONS AND REQUIREMENTS
15. EHB BENEFIT PLAN DESIGN
16. PROPOSED SUPPLEMENTAL BENEFIT PLAN DESIGN

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